Texas Department of Health
Toxic Substances Control Division
Environmental Lead Program

P.O. Box 149200
Austin, Texas 78714-9200
888/778-9440; 512/834-6612

APPLICATION FOR REPLACEMENT OF ACCREDITATION CERTIFICATE

INSTRUCTIONS: This form must be completed and submitted to the above address along with a $20.00 fee for each request for a replacement certificate. Send a cashier's check or money order payable to the "Texas Department of Health - 7C790-085." DO NOT SEND PERSONAL CHECKS, COMPANY CHECKS, OR CASH. A replacement certificate will be issued within three weeks of the Lead Branch's receipt of your request.

TYPE OF REPLACEMENT CERTIFICATE REQUESTED (Please check the box for the type of certificate desired)

9 Firm Certification Certificate	9 Training Program Provider Accreditation Certificate

Complete all applicable blocks (print or type only) of the following section.

Name of Organization	Telephone Number ( )	Fax Number ( )
Mailing Address	**City**	**State** **Zip**
Physical Address (if different)	**City**	**State** **Zip**

Accreditation number | | | | | | | | **Date issued (month/date/year)** ____ / ____ /____

Please call the Texas Department of Health, Lead Certification Section, if this information is not known.

Please state the reason that you are seeking a replacement certificate. If requesting a new certificate due to a name change, the original certificate must accompany this application. If the ownership has changed and the Lead Firm has changed hands entirely, the former principal(s) must close the certification in writing, and the new principal(s) must apply for a new Lead Firm certification: _____

APPLICANT VERIFICATION OF INFORMATION

I hereby certify that there are no misrepresentations in or falsification of the information submitted on this application. I acknowledge that any falsification or misrepresentation may result in decertification or deaccreditation.

***This application must be signed by the same authorized agent on file in the Environmental Lead Branch.**

Name and Title of Firm's Owner or Authorized Agent/Training Program Provider's Representative*	Title
Signature of Firm's Owner or Authorized Agent/Training Program Provider's Representative*	**Date**

DO NOT WRITE IN THIS BOX - FOR HEALTH DEPARTMENT USE ONLY

Date rec'd: ____ / ____ / ____ **Amount $**_____ **Budget #7C790-085 Remittance #**_____
Date reviewed: ____ / ____ / ____ **Reviewer's action:** 9 **Approved** 9 **Denied** **Reviewer's Initials** _____
Date reissued ____ / ____ / ____ **Expiration date** ____ / ____ / ____ **Date mailed** ____ / ____ / ____
Comments: _____